



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TEXAS 78265

Respondent Name

LIBERTY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-08-5827-01

MFDR Date Received

May 16, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...I am requesting medical dispute resolution on the following 12 codes presented to the insurance carrier for preauthorization. Each code was preauthorized by the insurance carrier. The said procedure was performed and now denial of payment by the insurance carrier, Liberty Mutual. As per TDI-DWC Guidelines, once a code has been preauthorized, it cannot be denied for medical necessity. Each one of these codes has been performed as documented in the operative report and has not been funded."

Amount in Dispute: \$5,451.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our rationale is as follows: 22851-Exceed billable units as inherently bilateral code and 50 modifier not applicable. Operative report indicates 1 level L5-Si. 22800-denied as included for examination under anesthesia and pain study. Supported by Medicare under Musculoskeletal (cpt codes 20000-29999). Paragraph C. Anesthesia. 62290x 3 denied as global per Medicare CCI edit to CPT code 63042-63044. 63011-50 exceeds billable units as inherently bilateral code and 50 modifier not applicable, 63011-22 denied as included in CPT code 63044-50-22 as same level/inter space L5-S1. 63042-50 exceeds billable units as inherently bilateral code and 50 modifier not applicable primary inter space. 63044 and 63044-59 denied as exceeds billable units for additional inter space. Only 3 levels/inter space documented per operative report L3-, L4-L5 and L5-S1. These levels were processed for payment for CPT code 63042-50 and 63044-50 x 2 and paid. "

Response Submitted by: Liberty Mutual Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2007	Professional Component of a Surgery	\$5,451.45	\$1,865.77

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.202 applies for professional services provided between August 1, 2003 and March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 364.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 21, 2007

- Z710 – The charge for this procedure exceeds the fee schedule allowance
- Z121 – Level II certified provider
- U849 – This multiple procedure was reduced 50% according to fee schedule or usual and customary guidelines
- U899 – Procedure has exceeded the maximum allowed units of service
- B207 – This is an unlisted procedure. Please resubmit with a more descriptive code
- B377 – This is a bundled procedure; no separate payment allowed
- X212 – This procedure is included in another procedure performed on this date
- Z711 – This charge for this procedure exceeds the customary charges by other providers for this service
- X901 – Documentation does not support level of service billed
- U693 – By clinical practice standards, this procedure is incidental to the related primary procedure billed

Explanation of benefits dated February 8, 2008

- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. Did the requestor bill CPT codes on the same date of service that are bundled?
2. Did the requestor submitted documentation to support fair and reasonable for CPT code 22899?
3. Did the requestor bill multiple procedures subject to the multiple procedure rules?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(b), “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.”
 - The requestor billed the following CPT codes on November 7, 2007: 63044-59, 63044-22, 63011-22, 63011-50, 69990-59, 20938, 22558, 22612, 22840, 22840-50, 20972, 63685-59, 62290-22, 62290, 62290-59, 22325-59, 22851, 22851-59, 99220, 22899-99, 63042, 63042-50, 63044, and 63044-50.
 - The insurance carrier paid for the following CPT codes: 63042-50, 63044-50-22, 63044-50, 20938, 20975, 22325-59, 22558, 22612, 22840, and 22851-59.
 - The requestor is requesting reimbursement for CPT codes: 22851, 22899-99, 62290, 62290-22, 62290-59, 63011-59, 63011-22, 63042-50, 63044, 63044-59, 63685-59, and 69990-59.
2. Correct Coding Initiative (CCI) edits were run to determine correct coding and reimbursement for the disputed charges. The following edit conflicts were found:
 - CPT code 62290x 3 is bundled into CPT code 63042 and 22258, therefore, separate reimbursement cannot be recommended for CPT code 62290 x 3.
 - CPT code 69990-59 is bundled into CPT code 22612, therefore, separate reimbursement cannot be recommended for CPT code 69990-59.
 - CPT code 63011 was billed with modifier 50 to identify a bilateral procedure, however the modifier -50 is not allowed when billing CPT code 63011. The requestor billed 63011-50 and 63011-22, the insurance carrier did not reimburse the requestor for this CPT code, therefore reimbursement is recommended for 63011-22.
 - CPT code 63042 was billed with modifier 50 to identify a bilateral procedure, however the modifier -50 is not allowed when billing CPT code 63042. The requestor billed 63042-50 and 63042. The insurance carrier paid for CPT 63042, therefore no further reimbursement is recommended for CPT code 63042-50.
3. Per 28 Texas Administrative Code §134.202(c)(1), “(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.

No CCI edit conflicts were found for the CPT code noted below, therefore, the requestor is entitled to reimbursement for the following CPT codes according to the multiple procedure rule:

- The MAR reimbursement for CPT code 22851 is \$495.16, the multiple procedure rule applies, therefore reimbursement is recommended at 50% of the MAR, \$247.58.
 - The MAR reimbursement for CPT code 63011 is \$1,478.50, the multiple procedure rule applies, therefore reimbursement is recommended at 50% of the MAR \$739.25.
 - The requestor billed 63011-50 and 63011-22, the insurance carrier did not reimburse the requestor for this CPT code, therefore reimbursement is recommended for 63011-22. The MAR reimbursement for CPT code 63011 is \$1,201.47, the multiple procedure rule applies, therefore reimbursement is recommended at 50% of the MAR \$600.73.
 - The MAR reimbursement for CPT code 63685-59, is \$556.42, the multiple procedure rule applies, therefore reimbursement is recommended at 50% of the MAR \$278.21.
4. Per 28 Texas Administrative Code §133.307(c)(2)(G) “(2) Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (G) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT code 22899-99, 63044 and 63044-59.
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for CPT code 22899-99, 63044 and 63044-59.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount order is \$1,865.77.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,865.77 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Margaret Q. Ojeda
Medical Fee Dispute Resolution Officer

February 22, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.